Away from Home Care Guest Membership and Follow-up Care Application

BlueCross BlueShield Association
An Association of Independent BlueCross & BlueShield Plans

A – SUBSCRIBER INFORMATION

Name:	**Social Security #**	
Address: _____ _____ _____	**Sex:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Divorced ☐ Domestic Partners ☐ Married
Telephone: Home: **Work:**	**Date of Birth:**	
Employer Name and Address: _____ _____ _____ _____	**Group #** **Type of Coverage:** ☐ Individual ☐ Family	**Employment Status:** ☐ Active ☐ Retired

B – GUEST INFORMATION

Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Dependent**

Name:	**Social Security #**	
Address Away From Home: _____ _____ _____	**Sex:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Divorced ☐ Domestic Partners ☐ Married
Telephone Away from Home: **Work:**		**Date of Birth:**
Medicare Enrollee? ☐ Yes ☐ No	**Medicare Type:** ☐ Traditional ☐ Medicare Risk ☐ Medicare Cost	**Medicare #:**_____ **Should the Host Plan (Out-of-California Insurance Provider) direct the patient to a Medicare Participating Provider?:** ☐ Yes ☐ No

C – CONTROL INFORMATION

Period Covered by the Guest Application: **From:**_____ **To**:_____

(Note: Must be between Three to Twelve Months for Spouse and Dependents & Three to Six Months for Subscribers. Must Be Renewed EVERY CALENDAR YEAR.)

Type of Service (Check One)

1. Guest Service:
☐ Families Apart
☐ Student
☐ Long-Term Traveler

2. ☐ **Pre-Authorized Follow-Up Care**

I hereby certify that all information stated above is truthful and correct to the best of my knowledge. I acknowledge that the benefit program providing coverage to myself or eligible dependents as guest members of the HOST HMO, may vary from the benefit program at my HOME HMO. I understand that as a guest member, the HOST HMO benefit program's scope and levels of coverage apply. (This does not apply to GM and Ford participants receiving home benefits.)

_____ _____

Subscriber Signature **Date of Application**